February 4, 2022

The Honorable Kevin Hern
U.S. House of Representatives
Washington, DC 20515

The Honorable Rick Allen
U.S. House of Representatives
Washington, DC 20515

The Honorable Victoria Spartz
U.S. House of Representatives
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The HR Policy Association and American Health Policy Institute submit the following recommendations for your consideration regarding your January 10, 2022, request for information asking for legislative proposals that will make health care more affordable.

The HR Policy Association (Association) is the leading organization representing chief human resource officers of 400 of the largest employers in the United States. Collectively, their companies provide health care coverage to over 20 million employees and dependents in the United States. The American Health Policy Institute (Institute), a part of the Association, examines the challenges employers face in providing health care to their employees and recommends policy solutions to promote affordable, high-quality, employer-based health care. The Institute serves to provide thought leadership grounded in the practical experience of America's largest employers.

The Association and Institute thank the Healthy Future Task Force for seeking input from employers on ways legislation can improve access, lower costs, and modernize the health care delivery system while protecting the employer-sponsored health care system. Our members work tirelessly to provide their employees with comprehensive health care benefits at a low cost, but many continue to struggle to keep costs down. However, the prices paid by commercial insurers and Medicare FFS differ significantly because commercial reimbursement rates are determined by negotiation whereas Medicare rates are set administratively by law and regulation.[1]

The fundamental affordability problem with the U.S. health care system continues to be prices.[2] Although there are utilization issues, with five percent of the U.S. population accounting

[1] Congressional Budget Office, The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services, January 2022.

[2] Gerard F. Anderson, et. al., It's Still The Prices, Stupid, Why The US Spends So Much On Health Care, RAND, October 17, 2019. Also see: PwC Health Research Institute, Medical cost trend: Behind the numbers 2022, 2021; and Audrey Kearney, et. al., Americans' Challenges with Health Care Costs, Kaiser Family Foundation, December 14, 2021.

for half of all health care spending in 2017,[3] the level of prices is the primary difference between U.S. health care costs and other countries. One 2019 meta-study that reviewed 43 original studies and 18 reviews covering 341 studies on the effectiveness of cost containment policies found cost sharing, managed care competition, reference pricing, generic substitution and tort reform to show promise.[4] However, cost sharing has reached its affordability limit for plan participants, and it generally has the unintended consequence of reducing the amount of necessary care plan participants utilize. A substantial body of evidence favors better coordination of care as an effective way to contain cost.

Our recommendations on ways to expand access to affordable coverage and care, foster innovation, increase quality and transparency while preserving employer-sponsored health coverage are below.

I. Improving Healthcare for America's Workers and Small Business Owners

Enact the Association Health Plans Act of 2021 (H.R. 4547)

While HR Policy Association members are large, self-insured employers, the Association generally supports Association Health Plans as a way for small employers to provide affordable health care benefits to their employees.

Simplify, Expand and Codify the Individual Coverage Health Reimbursement Arrangement (ICHRA) Rule

HR Policy Association generally supports ICHRAs but unless they are simplified and codified, large employers are not likely to implement them. According to the Kaiser Family Foundation, four percent of firms offering health benefits and seven percent of firms not offering health benefits offered funds to one or more of their employees to purchase non-group coverage in 2021.[5] Among all firms (offering and not offering health benefits) that did not offer funds to any employees to purchase non-group coverage in 2021, only one percent are "very likely" and an additional seven percent are "somewhat likely" to offer an ICHRA to at least some employees in the next two years.[6] Among large firms that currently offer or intend to offer an ICHRA, 44 percent offer or intend to offer an ICHRA to all their employees, 16 percent offer or intend to offer to part-time or seasonal workers, 60 percent offer or intend to offer to low-wage workers, and 19 percent offer or intend to offer to some other group of employees, such as only full-time employees.[7]

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[3] Emily Mitchell, Concentration of Healthcare Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2017, Agency for Healthcare Research and Quality, February 20, 2020.

[4] Niek Stadhouders, et. al., Effective healthcare cost-containment policies: A systematic review, Health Policy, January 2019.

[5] Kaiser Family Foundation, Employer Health Benefits, 2021 Annual Survey, 2021.

[6] *Id.*

[7] *Id.*

To increase employer interest in ICHRAs Congress should make it simple for employers to determine if ICHRA coverage is "affordable" for employer shared responsibility purposes; clarify that ICHRAs do not violate nondiscrimination rules and allow employers to provide information to employees regarding individual insurance coverage. Congress may also want to enable employers to offer ICHRAs to independent contractors. The Association further recommends Congress review the provisions and rules for HRAs, HSAs, employee-funded FSAs, QSEHRAs, ICHRAs, and the expired Archer MSA, and combine the best of them into a new funding vehicle. The Association has a draft chart here that maybe useful to the Task Force.

Implement a National Patient Safety Board to Reduce Medical Errors

Medical errors are a leading cause of death in the U.S.[8] Reducing these errors would significantly reduce U.S. health care cost for public and commercial payers. One report from the Betsy Lehman Center for Patient Safety in Massachusetts identified almost 62,000 preventable harm events that resulted in over $617 million in excess health care insurance claims.[9] A study by the American Health Policy Institute found $2 billion in wasteful and unnecessary health care spending – approximately 20% of total spending, in 35 company health care claims using VBID's Health Waste Calculator tool.[10]

The U.S. health care system should leverage its technology and information systems to protect patients and health care workers from harm by establishing a National Patient Safety Board (NPSB) modeled in-part after the National Transportation Safety Board (NTSB), with the aim of diagnosing problems and scaling remedies. A NPSB could analyze available data, identify preconditions for major harms, and invent and spread innovative solutions in a nonpunitive way. More information on this recommendation can be found here and here.

II. Promoting Employer Programs to Lower Costs and Improve Care

Strengthen ERISA Preemption While Providing Greater Flexibility to States

Before the Employee Retirement Income Security Act (ERISA), multi-state employers were subject to different state laws, which prevented the uniform administration of health care benefits, increased the cost of those benefits, and blunted the ability of large employers to improve the efficiency of the U.S. health system. In order to address this problem and to encourage employers to provide health care benefits, Congress crafted ERISA to supersede or preempt any and all state laws as they relate to any employee benefit plan as defined under the law.[11]

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[8] Makary M A, Daniel M. Medical error—the third leading cause of death in the US, BMJ 2016;353:i2139, May 3, 2016.

[9] The Financial and Human Cost of Medical Error and How Massachusetts Can Lead the Way on Patient Safety, Betsy Lehman Center, June 2019.

[10] David Edman, Paul Manz, Using Data-Driven Disruption To Reduce Wasteful Healthcare Spending, American Health Policy Institute, 2016.

[11] Vanessa Scott, The Need to Strengthen ERISA Preemption, American Health Policy Institute, 2017.

In addition, ERISA prohibits states from regulating benefit plans as insurance in an effort to circumvent ERISA preemption. These provisions generally protect self-insured employer-sponsored health care plans from state laws that would otherwise mandate benefit requirements or impose administrative burdens, bind employers particular plan designs, or preclude employers from implementing uniform plan administrative practices across states. As a result, ERISA preemption significantly reduces costs for self-insured health care plan sponsors, participants, and beneficiaries. ERISA's preemption provisions allow plan sponsors to seek lower-cost, nationwide pricing for health care services, allowing for uniformity of benefits design and equity across an employer's workforce. It also enables large employers to drive innovation in benefit and plan design, foster new health care cost controls, and improve the quality of care. These innovations have included consumer directed benefit designs, payment reform, provider transparency initiatives, and wellness programs. Any weakening of the foundation provided by ERISA pre-emption not only increases the cost and complexity of health benefits for employees and employers, but also frustrates further health care market innovation.[12]

Employers that operate across multiple States have stressed the importance of preemption under ERISA. According to a 2018 HR Policy Association survey of its members, when asked to select the top three factors out of seven that would serve as "tipping points" for their company, 37 percent selected, "Erosion of ERISA such that self-insured plans become subject to substantially differing state taxes and fees."[13] Furthermore, the increasingly disruptive effects of multiple states and localities adopting taxes, fees, and other requirements with respect to ERISA-covered plans demands Congress take action to protect the employer-based health care system.

While HR Policy Association generally supports providing states with greater flexibility regarding Affordable Care Act Section 1332 waivers, state waivers must not undermine the uniform design and administration of ERISA plans and must avoid imposing costs on employers. State waivers should not allow states to impose mandates, assessments taxes, fees, or new reporting requirements on self-funded group health plans.

Remove Barriers to Implementing Value-Based Care Arrangements

Many Association member companies are engaged in value-based care arrangements like Accountable Care Organization models to ensure they are providing employees with quality health care. Many of these contracts involve two-sided risk-based arrangements centered on metrics, like depression screening or diabetes measures, that are tied to both outcomes and patient satisfaction. However, these arrangements require significant market power on behalf of the employer to be able to negotiate with large hospital systems or providers. Even some of the largest employers struggle to implement these programs because they may not have a large enough market share in every state or geographic region in which they have employees.[14] This leaves significant portions of employee populations without effective programs that focus on improving quality while lowering costs.

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[12] *Ibid.*

[13] Henry C. Eickelberg, "Tipping Points" of Employer-Sponsored Health Insurance, American Health Policy Institute, 2018.

[14] Matthew Eisenberg, et. al., Large Self-insured Employers Lack Power to Effectively Negotiate Hospital Prices, The American Journal of Managed Care, July 13, 2021.

Many employers also engage in direct primary care arrangements (DPC) and HR Policy supports the Primary Care Enhancement Act (S. 128, H.R. 4301) which allows more employees the opportunity to access cost-effective primary and preventive care. These arrangements are also easier to implement than preferred provider partnerships for employers with smaller market shares. DPC arrangements allow primary care physicians to charge a monthly, quarterly, or annual fee for services, rather than charging on a fee-for-service model. These models have shown to demonstrate improved management of chronic conditions, decreasing inpatient hospital visits by 50 percent and emergency room visits by 20 percent and lower overall medical spend by 12 percent.[15] However, federal rules limit the employee populations that employers are able to offer these programs to. Currently, employees enrolled in a high-deductible health plan that is paired with a health savings account (HSA) are not eligible for these programs because of first-dollar coverage restrictions.

Association members also support the Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) which promotes the uptake of the Collaborative Care Model (CoCM) by providing grant funding to remove the barriers that primary care practices face when trying to implement the model. The CoCM creates a care team comprised of a primary care provider, psychiatric consultant and a behavioral health care manager. Over 90 randomized controlled trials have demonstrated collaborative care models are more effective and cost efficient than usual care.[16] Behavioral health conditions often initially appear in a primary care setting and primary care clinicians provide mental health and substance use care to most people with behavioral disorders, as well as provide the majority of psychotropic medications. However, most primary care physicians do not provide evidence-based care to these patients. An integrative model that joins behavioral health and primary care would significantly reduce the burden of other illness, reduce the demand for behavioral health services, lower medical costs, and reduce disparities in the identification and effectiveness of treatment for behavioral health issues.

III. Increasing Transparency and Marketplace Innovation

The Association strongly supports the hospital transparency rule, the transparency in coverage rule and the reporting requirements in Section 204 of Title II of Division BB of the Consolidated Appropriations Act, 2021 (CAA). Our members recognize the importance of increased price transparency for consumers but believe the biggest impact will come from the availability of data for self-insured employers to use to improve their networks, increase quality, negotiate lower prices on behalf of their plan participants, and better implement value-based plan designs. While price and quality transparency tools can make an impact on plan participants' health care purchasing decisions, a large percentage of health care is not "shoppable" and in a complex health system engaging in price shopping is the exception, not the norm.

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[15] Clayton Christensen, et. al., The Innovation Health Care Really Needs: Help People Manage Their Own Health, Harvard Business Review, October 30, 2017.

[16] Jürgen Unützer, et.al., The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center, May 2013.

The Association recommends the Task Force codify in one place the hospital transparency rule, the transparency in coverage rule, the CAA reporting requirements and other price and quality data measures. Congress must also recognize that employer plans often do not have access to the claims data the current rules and statutes require them to report, and they should require reporting from the actual entities that directly hold the information rather than compel employer plans to get the data from third, fourth or fifth parties down the various health care supply-chains. Employers should also have unfettered access to all of their claims data.

Reports that most hospitals are not compliant with the Department's price transparency requirements are disappointing, but not surprising. Employers have long struggled to utilize claims data to reduce costs as many in the health care supply-chain claim the data they handle is proprietary. The Association recommends Congress enact significant penalties for noncompliance, and this noncompliance should extend to the useability of the data. Information that remains too restricted or complicated for consumers to understand will not be utilized.

Current versions of price transparency like hospital chargemaster lists, which show list-price data, are not relevant to patients who rarely purchase an individual service and typically do not know what services they will need when going to a hospital. Given that most hospital stays include several services bundled into the care for a general treatment or episode of care, like a hip replacement, the pricing information provided to patients should reflect this. Additionally, published list prices often do not apply to patients with insurance as insurer-negotiated rates and cost-sharing mechanisms like deductibles and co-pays differ among insurers.

IV. Increasing Competition and Identifying Anti-Competitive Consolidation

Prohibit Anticompetitive Practices in the Pharmacy Supply-chain

Rising drug prices are one of the top three health care cost concerns of HR Policy members. To increase competition and reduce drug prices in the pharmacy supply-chain the Association recommends Congress:

- Eliminate "patent evergreening" and other "patent thickets" to ensure that branded products will face competition from generic drugs and biosimilars in line with the intent of current laws.
- Prevent first-to-file generic drug applicants from blocking, beyond a 180-day exclusivity period, the entrance of subsequent generic drugs to the market.
- Reduce citizens petition abuse by giving the FDA additional guidance on denying petitions submitted for the purpose of delaying generic approval.
- Require branded biologic companies to publicly list drug patents they can reasonably defend.
- Enable purchasers to accept or reject spread pricing by pharmacy benefit managers, health plans, providers, and other intermediaries. This policy should apply to drugs administered directly by providers and sold in the pharmacy setting.
- Oppose policies that would limit the ability of employers and purchasers to manage their drug costs including banning step therapy and generic substitution.

Prohibit Anticompetitive Contracting Provisions

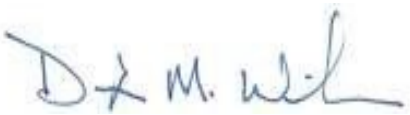
It is not uncommon for health care providers with significant market share to require employer plans and carriers to contract with all affiliated facilities and prevent educating plan participants about the lower-cost, higher-quality care options they may have available to them. These anti-competitive contract terms are often referred to as "all-or-nothing," "anti-steering," "anti-tiering" and "most-favored-nation" contract provisions. These contract provisions can significantly limit employer plan innovation and flexibility to promote access to high-quality lower-cost care. The Association recommends the Task Force prohibit these anti-competitive contract terms that raise the cost of health care. One example of this is the bipartisan Healthy Competition for Better Care Act (S. 3139).

V. Conclusion

Private business health expenditures were forecast to increase an average 4.8 percent per year for the next seven years before the overall inflation rate went from 1.2 percent to 6.0 percent over the past year. If previous trends hold, employers could be facing health care costs rising 7 to 9 percent in 2023, a trajectory that will make it increasingly difficult for employers to offer affordable, quality health coverage. Going forward, all stakeholders – employers, providers, insurers, intermediaries, individuals, and government must be willing to compromise and be accountable for healthcare reforms that will benefit all Americans.

Your request for information on legislation to improve affordability, increase transparency, and lower barriers to competition is a positive step. We look forward to working with you to develop legislative proposals that will enable companies to continue to provide high-quality health care benefits to over 177 million Americans.

Sincerely,



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